Wonderful treatment

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Introduction

A friend of mine once had the misfortune to suffer acute appendicitis and be admitted to hospital for emergency surgery. The operation was uneventful and wholly successful, my friend recovered in a manner and at a rate that was typical for his age (he was at the time in his forties) and he was discharged, went home, and soon resumed normal daily life. Notwithstanding the original misfortune, the whole episode was otherwise entirely unremarkable from a medical viewpoint. However, telling me about it later my friend described the familiar signs and symptoms of his digestive system starting to work again as he convalesced and, as he put it, from his perspective as a biologist 'It was wonderful to observe my digestive system – my body – coming back to life.'

The treatment involved in his case, appendectomy, is in biophysical terms well understood, as is why it should be needed and how it works. It is, from a surgical perspective, entirely ordinary and routine, even mechanical – hardly the stuff of wonder. And yet, as my friend – himself a trained biological scientist – observed, its result was in part wonderful. In this chapter I want to explore, and defend, that remark, and I want to do so in the context not merely of my friend's treatment but of the idea of treatment as such. Successful or otherwise, all treatments, I will suggest, are at least partly wonderful.

This is perhaps such a surprising claim that it needs some clarification here, right at the outset. Three of our patients might protest against the claim – Jake hotly; Liz and, perhaps, Jen in more muted and inward terms. Jake's defiant "I don't want any more tubes stuck up and through me. I'm not a freak… I don't want any more of those bloody tests and I don't want any bloody pills either" is no endorsement of the wonder of treatment. Liz's treatment elicits her twitches, groans, revulsion, nausea – as well as her disbelief that any woman might actually want to watch the proceedings on a television monitor. Jen endures humiliation at 'her body letting her down'; 'How many times do I have to do this? How will I ever cope?". She is amazed at what she does cope with; but any wonder here seems directed at her own resilient spirit than at medicine's efforts.

So let my clarification start with what I am not claiming – that individual treatments are unfailingly occasions for grateful joy. Even when they are free of discomfort, easily tolerated, and rapidly effective I am not claiming that, in showing this, we have disclosed what makes them wonderful. Nor is their wonder a matter of technical bravura. Admittedly it might be said that, in the accumulated observations that led to a treatment's being conjectured and refined, or in the intelligence through which theoretical understandings of the body explain how a treatment can

work, or in the meticulous practicalities of the way a treatment is administered, all treatments (or at least all those that work well) represent wonderful gains in our understanding and therapeutic capacity. But such wonderfulness is temporary, simply part of our acknowledgement of something novel, our relieved greeting of another victory in a long struggle. The enduring wonderfulness of treatment lies elsewhere, and indeed it permeates the very idea of treatment.

Treatment consists – and its wonderfulness is provoked – in the interaction between the therapeutic procedure and the person treated: in the inducing of change in the bodily make-up of the patient; in the deliberate constructive alteration of the patient's embodied experience; in short, in meddling in the flesh of another person. What is wonderful is that this is possible; that it works as often as it does; and, most of all, that it works because our world and our experience of the world are embodied in our flesh.

To change our flesh is to change – hopefully, for the better – the way that we experience the world. This embodiment, of which we are forcibly reminded every time we try to affect it by direct physical intervention, is enduringly wonderful. From embodiment's wonderfulness, the wonderfulness of treatment directly stems.

Bodily wonder

ordinary living, being and doing: what we take for granted

I have noticed elsewhere1 the virtues of Rene Leriche's remark that 'health is life lived in the silence of the organs'2. Shrewd though it be, the remark has its shortcomings, among them that it ignores the obvious fact that the skin is one organ whose silence is not a precondition for health. In all sorts of ordinary doings and undertakings in daily life our skin will register all sorts of sensations including discomforts and irritations. When we try to stop still for a moment our attention is sometimes freed to register these discomforts. It happens that I am writing the present lines on a laptop computer which for once does indeed sit in my lap; I'm virtually encased in an old armchair, perched just in front of the full-height windows of an upper-floor lounge, looking out over the garden. Right now I would describe myself as perfectly healthy, although – now that I pause to register the facts – my arms are irritated by the rough wool of my sweater, the cushion in the small of my back seems always in the wrong place, my chair forces upon me a maddeningly crooked posture, I've an excessively acidic tang in my mouth from drinking strong tea earlier and my stomach is restless for some food; and finally my reading glasses make the garden through the window seem a dim and misty place. None of these discomforts seems to have any bearing on my conviction that I am in normal health; each of them however is a reminder of the essential physicality of experience whether as foreground or as background.

Our bodies make our worlds just as in turn they are made by those worlds. When I was younger I liked the appearance of my hands – small, neat, lithe, a pianist's hands as well as a furniture-maker's hands. Now (thanks partly to years of exposure to the sawdust and solvents of the furniture trade) my hands look considerably older

than I do, and I will consider this change further in a little while. But despite their appearance my hands continue to work, and well enough. They act in the world yet I have not the faintest conception of how my thoughts and intentions, in terms of the words that I want to type, can possibly actuate the accomplishments of my hands, in terms of sequences of keystrokes correctly delivered; more generally, I have not – and it seems to me that I cannot have – any true and deep conception of how my will is manifest in physical action. (The best account – that of Schopenhauer, according to whom the action is nothing other than the intention observed from outside, and the intention nothing other than the action experienced from the inside – solves the puzzle only by attempting to dissolve it, almost to deny it as a puzzle at all.3) Equally, experience is the inward expression of outward events and processes: yet I have not the slightest conception – and it seems to me that I cannot have – of how the physical, material sequences of touch and sensation and perception become manifest in the non-material reality of felt, qualitative experience.

This brings into sharp focus the primary ground of treatment's wonderfulness – the incredible constitution of experience, even the possibility of experience, by that subtly and minutely organised substance that we call flesh. Nowhere is this more graphically laid bare for us than by the sometimes-questionable products of Gunter von Hagens's 'plastinated' anatomical dissections. Even before we come to the dazzling array of neural circuitry within which we take consciousness to have its chief administration, the possibility of continued animal life lies spectacularly in the visceral manifold lying with the chest and abdomen. These engines of circulation, respiration, digestion, cleave together in a complex, coloured, congested heap of flesh; its untidy, haphazard scrambling nonetheless conforms closely to a regular blueprint – a blueprint that sustains all higher forms of air-breathing, warm-blooded, locomotive life.

This gaudy pile, in equal measure revolting and wondrous to behold, is our inner permit to exist at all; without it our brains and sensory organs can neither function nor arise in the first place. It is the 'soft machinery'4 that causes Liz's world briefly to swim and dim as the shocking aspects of her treatment fully register, that turns Jen's bed abruptly into a latrine; yet upon this machinery they – we – depend utterly and moment-by-moment. It is the boiler-room of fleshly life; and our life is a fleshly one.5

the dazzling richness of perceptual experience

Nowhere perhaps is the 'taken-for-grantedness' of our condition more remarkable than in ordinary perceptual experience. We accept without question just those five primary senses through which we engage the world, even construct it, and we give barely a thought to the other ways in which the world might – must – appear to other kinds of creatures: we take the world at face value, presuming that the face it shows to us is of necessity its real face. Just as effortlessly we embrace the contrasting modalities of the different individual senses, and their fusion in a single, continuous world of multi-modal experience. Thus we accept without question the activeness of touch, and we have no difficulty intermingling active tactile experience

with the helpless passivity of hearing. We accept without question the precise and stable structural repertoire of the illuminated world within our incredibly finely-grained visual field, alongside the rich chaos of fleeting, evocative, often un-nameable swirls of scent and flavour that assail our senses of smell and taste: the velvet pink petals and heady scent of an opened damask rose offer a single, albeit complex, fused experience. And we almost invariably overlook proprioception – our inward, 'blindfolded' knowledge of our own moment-by-moment orientation, posture, extension – in whose absence we couldn't walk or raise a spoonful of food to our mouths without constant visual monitoring and correction of our movements.6

Each of our senses can give us pleasure, and each can give us disgust – although now it becomes more apparent that our reactions, be they of delight or revulsion, involve thinking and imagining directly in the identification of what it is we sense or perceive. We don't see or touch or hear things innocently: they carry meaning for us even before actual sensation (which is in part what sensory recognition comes to). Even smell and taste, which might seem to affect our experience with particularly unavoidable immediacy, can be modified by expectation and imagination (a smell like strong cheese is enjoyable if it is clearly associated with actual strong cheese, and anything but enjoyable if its source lies elsewhere, and this remains true even if the source is a matter of what we merely believe rather than actually know to be true). Sensory experience can be frustratingly 'thin' – think of the use of sensory deprivation as a punishment – or it can be overwhelmingly intense, even in the absence of direct stimulation of pain. Sights and sounds and flavours can be simply too much to take in all at once; we have limiting comfortable levels of sensory experience, as well as enjoyable or aversive characteristic objects of that experience.

Any and all of this might have been otherwise, but it is not otherwise; the facts of our perceptual life are as they are. Our sensory experience is contingent, intense, close-knit, almost entirely continuous, and rich beyond measure. At the same time it is curiously limited: we have no intrinsic sensory experience of mass; we cannot feel magnetism; we are blind to all but a fraction of radiated energy frequencies; we have only a coarse awareness of pressure variation; we cannot 'meter' the passing of time, and so on. Perhaps above all, though, our sensory experience is unconsciously integrated: we have no awareness of the joining together of the multiple worlds of sound, space, sight and smell into a single world of embodied existence. They are co-fabricated in our brains, fused with our equally-unquestioning sense of our own identity and continuity, into what Kant intriguingly called the 'manifold of perception'.7 The world's muted daily ordinariness – but also its breathtaking dynamism and beauty – arise in and through this glorious symphony of sensory embodiment.

And its greatest glory is also its greatest wonder – the wonder that we can have this inward, felt quality of sensation at all: the wonder that sensory experience is not simply information enabling us to negotiate a survival in the world around us but rather the vivid aliveness of being embodied creatures in a material world. Our experience is the world – a world of externalities that, in and through our consciousness (and presumably the consciousness of many, many forms of animal life), has been given a qualitative, felt, 'inside'. Nothing, it seems to me, is more wonderful than this. Only slightly less wonderful is its modulation by medicine.

the material grounding of behaviour, in sickness and health

Not only do we sense and experience the world around us: we act in and on it. And just as our perception is the experiential 'interior' of material things and processes, so our actions are the experiential 'interior' of the processes by which we govern and are governed by the material world. We habitually and unhesitatingly act and move fluently; we think, do, respond to and immerse ourselves in a rich, multi-sensory and above all embodied world – doing all of this generally without conscious effort; fluidly, often carelessly; mostly without wonder.

Our baseline for effort or conscious attention rests both upon unthinking embodied fluency and upon the automatic coherence we somehow make of our kaleidoscopic sensory experience. Equally it seems that our baseline for intentional action is blindly governed by patterned physical interactions at the biochemical and biomechanical level. We are almost never aware of these interactions, some of them in turn governed by unalterable patterns in our genes and others by adaptive patterns in our nervous systems. We can do nothing about (though perhaps we could do little without) the instincts that are characteristic of our biological species, and that fit us generally to survive in physical terms. Our 'primitive reactions'8 are our broadly-shared genetic blueprint coming to life, for the most part protectively, in our outward behaviour – turning abruptly at a sound or at a tap on the shoulder, recoiling from painful or disgusting stimuli, scratching an itch, seeking out warmth and light and comfort, enjoying sounds within a certain range of pitch and volume and consonance, trembling when afraid, hesitating at the unknown, acknowledging the human face and its likenesses, attending to the sound of human (and other mammalian) infants, and – I dare say – sometimes gazing in rapt wonder at what is remote.

These reactions are built-into us regardless of when or where we are born. Other reactions come about, or are at least activated, by the cultural and social environment surrounding us. Our social habits, our learned conformities, become automatic and in time quite as unconscious (subjectively speaking) as our biological reactions. This is true also of our idiosyncratic behaviour, our individual habits that had perhaps a conscious beginning but develop a life and compulsion of their own, moulding the way we speak, act, and think.

The first wonderful thing about all of this – comparable to the wonder of materially-grounded perceptual experience – is how essentially simple chemical interactions can in predictable combination generate reliable, repeated, complex behaviour. This is already wonderful enough in the case of more specialised creatures than ourselves: for what essentially chemical combination of the actions of genes could possibly 'code' in a reliable, causal, manner for the building of a bird's nest, still less for a social artefact such as a beehive where the interactions of different individuals and their roles make a kind of unconscious joint authorship of such beautiful structures? But staggeringly, in our own case the mechanical influences of our genetic complement enable enormous flexibility and adaptability; they produce our seemingly unopposable mixture of curiosity, risk-taking, individual aggrandisement and collective prudence.

The second wonderful thing about embodied action is what it feels like, in ordinary health. We take for granted (to the point of almost never finding time to recognise and revel in its wonderfulness) our fluent, carefree, agency in the world. Our experience of our actions is of a physical body moved by will; yet our material reality is of a will both fuelled and constrained by physicality. We feel as though our bodies enact our will; it would be truer to say that our wills express our bodies. The Cartesian conceit under which we normally labour would be wonderful enough, of course; but no less wonderful is this idea of channelling, into concrete deliberate action in the world around us, new combinations of those felt impulses and possibilities that are fabricated in our flesh by genes, instincts, and habits.

To be in ordinary health is, in part, to be and to act in this ordinary way, taking our ordinary being and our ordinary acting for granted, utterly unaware of what underlies them.

illness and other metamorphoses

Perhaps this taken-for-grantedness explains our sense of absurd contingency about falling ill, a sense positioned somewhere amid bafflement, outrage and embarrassment. One moment we are engaged in the ordinary affairs of living – absorbed, preoccupied, or bored as the case may be – and the next moment all our calculations are set aside, all our taken-for-grantedness is thrust back in our teeth. Like accidents, illnesses should not happen but they do. They should happen to other people, in other lives, yet they happen to us, in ours. They should not happen now, so inconveniently, but in the future when we can afford the luxury of the time and attention that illnesses demand; but they will not wait for us. Or they impertinently remind us of our own behavioural choices, the risks to which we've exposed our health; and it seems (as John Diamond brutally illustrates in his autobiographical C9) to us that we were unfairly dealt with when we fail to 'get away' with risks run blithely and successfully by others.

However in bringing about unwelcome change, illnesses serve doubly to emphasise the general point that concerns me here: they remind us forcibly of the materiality of our existence, and they remind us of how tightly we are bound to it. Perhaps it takes as much self-mastery to be able to ignore pleasures as to be able to ignore pains, but illnesses change not only how we can be (our moment-to-moment experience) but what we can do and attempt. Moral fortitude may help us bear up under immobility and weakness, but it can do little about the basic limitations that these force upon us. The disruption and alteration of our ordinary existence and function is in its way only one more manifestation of the wonder of embodied experience. While it lasts, illness transforms the world – something as worthy of wonder as it is, for a time, shocking – but it also, astonishingly, can transform our own materiality.

Of course, whether well or ill, we are all helpless passengers in the long, slow, train-crash that is ageing. The poet Philip Larkin compared the hands of the elderly to toads – pudgy, wrinkled, inflexible, mottled.10 Two toads, unhappily, now squat on the keyboard of my laptop; they are part of me, and my access to the world through them is the same as it ever was; but falling within my own view they strike

me unfavourably as (I imagine) they do others. Blooms that are now rather shrivelled, they are still my trusted ambassadors in the world immediately around me but they no longer advertise or introduce my former, youthful self. Yet – occupational injuries and spills apart – I have not consciously brought about this metamorphosis. I have not even tried to stop its effects with moisturising or alleged 'anti-ageing' creams as so many people, men included these days, try to do. My hands' metamorphosis is part of me yet independent of me. And it forcibly reminds me of the contingency of my body. Here it is – a bag of meat and offal and bones, as Bryan Magee brutally puts it – that has slowly, over a lifetime, extruded itself out of available matter and space to occupy one (and one only) of infinitely many possible variations on the basic human form.11 I'm stuck with it; I'm stuck as it. Here my toad hands squat in front of me and neither I nor they can do a thing about it in any fundamental sense.

But although all this sounds rather sour and resentful, it is also a recognition of something wonderful. Toad-like or not, my over-aged hands are one illustrative aspect of the wonder of the gross morphological changes the human body undergoes over a lifetime. A typical human proceeds from conception through explosive gestation and live birth, to a parade of changing body forms and facial appearances in infancy, childhood, puberty, maturity, reproductive prime, the long middle years, elderly decline, death, disintegration: every aspect of this deserves wonder.

I recently gazed, transfixed, at the youngest occupant of an American paediatric intensive care unit. Not only had I no personal connection with this desperately fragile infant; more shockingly, given the child's heartbreaking prematurity, his appearance was such that at one level it was hard to recognise between us any classificatory connection as humans either. The tiniest living human I have ever seen with my own eyes, this looked more like a shrunken rubber balloon with spider limbs and a perishable, convulsing, cling-film surface. Intubated, bandaged, blindfolded, wrenched by natural mishap from the uterus where he might have flourished, clinging to life by means that were as much metaphysical as physical (I mean, his sheer will-to-live), he had become the pulsing junction-box for all the sterile electro-mechanical machinery around and partly within him. In safer circumstances it is obvious that through this crucible-stage we have all, each one of us, voyaged – foetally curled and amniotically swathed rather than spread-eagled supine upon a cotton sheet in sterile air. This infant had wonder within him: against all odds he still lived (and, perhaps, lives still; an email enquiry would disclose the facts but I have not the courage to send it). Yet also he had wonder around him, in the institutional love – there is no other word – that invests such technical bravura in his struggle to live another day: and furthermore he emanated wonder in the invitation to see him as one of us.

It is remarkable that those who know us as individuals recognise a continuing underlying experiential unity – we might, though need not, call it 'identity' – through the gross outward changes (a favourite party game challenges participants to recognise their friends from childhood photographs); but in some ways it is still more remarkable that we recognise this continuity in our own experience: that a rich 'I' persists doggedly and in later years stoically through physical metamorphosis of a kind that, if compressed, would be the stuff of nightmares.

In a sense, an intense compression of this sort actually is involved in the metamorphosis of illness. This can be acute and frightening, as Jane Macnaughton noted in the case of the child whose face 'disappeared' as her connective tissue desiccated (albeit temporarily) before her parents' horrified gaze.12 But the metamorphosis is still remarkable even in less extreme cases: weight may be gained or lost in significant amounts; limbs and joints swell alarmingly with inflammation or oedema; there may be colour and complexion changes in fever; fluids may accumulate or leak out; there may be unorthodox growth – new tissues in new shapes, tumours, scars, keloids. Or there may be a 'kinetic' metamorphosis – a change in the nature and range of movement, a speeding up, a slowing down, spasms, rigidity, tremor. And so on. To us who – as we often believe in times of health – 'inhabit' our bodies it becomes clear during illness that we are our bodies, for better or worse, and that our bodies are changing in a way that seems to be at odds with our continuity as selves.

Wondrously of course, the metamorphoses of illness often go into reverse, sometimes just as quickly as they came about. We often do recover our former poise, posture, balance, watertight-ness, colour, odour, mass, shape (or at any rate most of it), with perhaps a residue of the change left in terms of scarring or stiffness as a longer-term legacy. Again, the continuity of the self persists through the metamorphosis. However, sometimes metamorphosis is not merely a result of a treatment, it is constituted by the treatment. This is typical of surgery – the cutting out and removal of obstructive or intrusive or dangerously broken flesh. For Liz the pervasive, persistent horror of her own treatment was the excision of a biopsy with an electrical loop: "…a sense of heat, the smell of burning flesh. This smell was the worst thing of all." Part of her had been both removed and, unavoidably, presented to her nostrils for what it had been changed into: burnt meat. This is a truly graphic form of what I earlier called 'meddling in the flesh'. For the physician, the experience is doubtless masked by routine; but for Liz, a conscious patient, it is an existential threat, a reminder that what can in the right circumstances be appetising is also, in the wrong circumstances, a vignette of fiery death.

Those who administer such treatments do well to be mindful of their ambiguity, and this is equally true of far more mundane things than excision. When Jen's cancer nurse brings her a wig in preparation for the impending loss of her hair, Jen is transported back to her youth and to the beauty of 'her swinging chestnut bob … her best asset'. Perhaps her hair is no longer chestnut, and indeed its greying and crisping are part of Jen's life-cycle metamorphosis, but it still connects her with the selves she is losing – her own and Geoff's alike in their handsome youth, Geoff's now in most senses, given his withdrawn and unwitting state. The wig is kindly meant, a form of palliative treatment, but for the moment at least it is for Jen anything but a comfort.

When we do recover, it is of course a wonderful thing in every sense to regain ordinary embodiment and perception and function and self-experience. In terms of ordinary embodiment, when my friend coolly watched over his own recovery from appendicectomy, what was at stake for him as a biologist was among other things a kind of existential demonstration of the principles of biochemistry and physiology. That gaudy 'heap' of viscera had suffered the insult of surgery, ridden the blow, recoiled, sprung back into place, recovered its poise. Human interference had

altered its circumstances, brutally, though intelligently and constructively, and in response that same 'heap' had spontaneously – spontaneously – resumed the ordinary business of being organised flesh. Knowing how it happens is not the same as knowing why it happens, and it seems to me that at a deep level we do not really know either why or how.

Other wonderful aspects of recovery appear within our embodied experience. What had become stale to us before falling ill can taste fresh again; neglected pleasures present themselves for reconsideration; we have the chance to make new resolutions (however fragile) about how we will make better use of our regained health and strength. All these good things are – or would be, did we not habitually forget them – the opportunities of ordinary embodied life. More particularly they belong to those holding, as Sontag puts it, passports in the 'kingdom of the well';13 by contrast they are just what are longed-for by the sick. In 'The Building' Larkin cruelly picks bare the hospital in-patient's longing for the free outside, with all its wonderful, reckless, humdrum ordinariness that is (seemingly) forever denied him.14 In a less literal sense he is describing Rachel, too – not in hospital, but just as assuredly imprisoned by her diabetes, when an adult's caution prevents her from enjoying the treats of a school trip. At an alternative holiday camp for other diabetic children she would be one among many 'exactly like me … I'll have a lot of fun and I'll be ordinary. Believe me, that would be the best thing of all.'

We have throughout been recalling the extraordinary wonderfulness of ordinary embodiment; but it has taken us some philosophical effort to do so. For those whose illness has deprived them of ordinary being, recalling it needs no such effort. The trouble lies in reclaiming it, and this – or as much of it as is possible – is treatment's aim.

Existential wonder

that we are here at all

Whenever an individual patient receives treatment, that treatment is a response not merely to a given systemic (physiological, biochemical) disruption but to a disturbance in that remotely improbable material accident that constitutes each one of us. So is it not wonderful that we are here at all? Bill Bryson puts the point inimitably:

> For you to be here now trillions of drifting atoms had somehow to assemble in an intricate and curiously obliging manner to create you. It's an arrangement so specialized and particular that it has never been tried before and will only exist this once … letting you experience the supremely agreeable but generally under-appreciated state known as existence. … For all their devoted attention, your atoms don't actually care about you – indeed, don't even know that you are there. They don't even know that they are there. They are mindless particles, after all, and not even themselves alive. (… If you were to pick yourself apart with tweezers, one atom at a time, you would produce a mound of fine atomic dust,

> none of which had ever been alive but all of which had once been you.) Yet somehow for the period of your existence they will answer to a single rigid impulse: to keep you you.15

Both illness and treatment are – in different ways – organised disruptions to an existing 'arrangement' of atoms (only the agencies of disruption are different). Treatment is not conceived in these terms, of course, but nonetheless in material terms that is what it comes to. This uncomfortable equivalence is very present to Jen, who feels her body is 'letting her down' in response to treatment, notwithstanding that it is precisely because her body has (as it were) already 'let her down,' in falling ill, that the treatment is being offered. The resemblance goes further: seeing how focused the nurses are 'made her realise, as nothing had, that the treatment was serious. Cancer was serious.' At some stages of her treatment, Jen will find illness and treatment partly indistinguishable. Both the cancer and the chemotherapy are organised disruptions to her body's patterns, and her atoms' arrangements.

Treatment is possible of course because (astoundingly) our 'arrangements' are patterned in ways so consistent that, as organisms, we can conform to a specification allowing us to come into the world, survive, beget offspring, and even come to a rudimentary understanding of what our patterns are meant to be and how they might be restored. In drawing on an understanding of this conformity, the fact and success of treatment invites a further level of wonderment.

Yet still more wonderful is the accident (unless one's religious belief suggests otherwise) that at some level of increasing complexity amongst simpler, inert forms of matter an entirely new phenomenon emerges – consciousness, finding (so far as we know) its highest and perhaps only truly self-reflective form in embodied human nature. We are fantastically complex arrangements of very simple, very inert, parts. How mere complexity gives rise to the inner reality of sensation – let alone experience and self-reflection, and the ability to ponder questions of wonder – is as much a philosophical as it is a scientific mystery: perhaps more so. Treatment is ordinarily an intelligent, purposive, intentional and inter-personal activity. In the clinical consultation two intelligences – two emergences of intelligence from patterns of mere inert matter – jointly consider the problem that one of them has an altered experience. This is already astounding enough. But in treatment, they intervene in the pattern, in the 'arrangement', hoping thereby to intervene in the experience. In recognising this, we are drawn to further wonder. And in recognising this – this 'drawing to wonder' – we open the door to ontological wonder: wonder at ourselves, our agency and, indeed, our own capacity to wonder at all. Through our wondering, the otherwise material Universe wonders at itself; and heady though this thought may be, it suffuses the wonderfulness of treatment.

that we are capable of ecstasy and agony

The imagination is involved in ecstasy as much as in the agony of suffering. If we have led anything like an ordinarily fortunate life we will know at first hand most of the characteristic forms of sensory ecstasy, but we derive the fullest enjoyment of

them through the imagination: anticipating, savouring, remembering them as well as – in effect – 'enduring' them. Like the minor irritants of an almost-comfortable posture that I described earlier, the ecstasies of the senses give the lie to Leriche's otherwise attractive view of health as 'life lived in the silence of the organs'. But they take their identity in contrast to the ordinariness of what plausibly is organic 'silence'. Ecstasy makes a pleasing poetic contrast with agony, but its existential contrast is with dull flatness, with tedium or with simply not noticing. Ecstasy is a special kind of noticing or attending, with always a small part of the attending being reflexive, turned back on itself, relishing the self-acknowledgement involved. In its way ecstasy involves a form of wonder because the imagination itself is an instance of what is wonderful, as well as the means through which we can recognise wonder. But – soberingly – this must also be true of suffering. The very root of wonder found in ecstasy has its baleful counterpart in the imaginative dimension of suffering: we are such creatures as can not merely experience pain but be tormented by it in anticipating it, abjuring it whilst undergoing it, and remembering it even as we claw our way back out of it. Suffering involves a reflexive act of the imagination, something as regrettably worthy of wonder as ecstasy is ebulliently worthy.

In this sense, treatment often aims at transforming the content of the sensory provocations of our imaginations. Sadly treatment itself may, en route to perhaps a successful conclusion, provoke our imaginations adversely. Some of those undergoing chemotherapy suffer 'anticipatory vomiting' in the days or hours before a treatment cycle; the knowledge of what lies ahead is enough. Jen's imagination thrust tuberculosis far deeper than cancer in its perceived threat to her, and only the seriousness of the treatment she is in fact to receive reveals the seriousness of the disease she actually suffers. Poignantly, as we've seen, her imagination has also burdened the cosmetic provision of a wig with grievous symbolism.

our existential 'metamorphosis'

We earlier reviewed the astounding metamorphic career of our physical forms, from conception to disintegration. It's of course matched – with due allowance for individual variations and cultural modifications – by the metamorphic career of our selves as agents. We begin and all-too-frequently end in helplessness both physical and intellectual, though the resemblance perhaps stops there. The will-to-live that commands our infant bodies' growth – via our carers' attention – has a mordant echo in death-struggles, but there it will not strike others as having the same sense-making basis that nurtures the infant as such. But the will-to-live is for most of our lives obscured by the will-to-do, especially in such agent-centred contexts as liberal industrial societies.

Ask people when was the best time of their lives and they may well respond in terms of the period when they most felt they could act as they willed, when they most felt in control of their futures. Both in bodily and in spiritual terms, it is common for us to find a sense of invincibility in our prime – whenever we take that to be – replaced by doubt and scepticism as the next step in a relentless transition to what we may expect to be shocking vulnerability in decrepit age, and ultimate dissolution. Ignoring the intervening stages, how can it be possible that a will, an

agency, can come into being from nothing; act for a while purposively and even (apparently) without impediment on life's stage; and then diminish into annihilation? The great actors of history may have shaped the world we live in today without the slightest possibility of their acting again in our own time. Some very few of us (as I write, the inspirational Burmese opposition leader Aung San Suu Kyi has just been released from house arrest) might move continents in their own lifetimes without the slightest prior basis in action before those lifetimes. At all levels of effect and power, human agency is somehow born of nothing and for a while simply cannot be repressed – it bristles and sparks and shoves almost unceasingly – and then it declines into extinction and, in most cases, oblivion as well.

A paler reflection of this, though in existential terms at least as terrible, is the rise and fall of cognition – one of agency's aspects in the ordinary case. Minds arise without antecedents, and minds disappear – mostly without trace. Is this not to be wondered at?

Treatment (for example in addressing metabolic or psychotic disorders) can aim at adjusting the speed, the shape, and to an extent the duration of this metamorphic career 'curve'; and this is wonderful enough in itself. But the basic framing of agency is beyond treatment's scope. Geoff's plight consists in part in the untimely loss of agency through his losing social awareness and interaction. One of the ironies of his treatment is that what it achieves – a 'lightening of mood' that is noticed, seemingly, only by the clinical staff at his nursing home – seems to benefit others rather than himself. His interactions with them have dwindled to little more than disturbances among his body's reactions of which he himself appears unaware. His 'existential metamorphosis' is prematurely complete.

Wonder in practice

In this chapter I have tried to take wonder seriously as underlying and revealed in treatment: successful or otherwise, tolerable or otherwise, the very conception and ambition of treatment rests on (as well as intervenes in) the larger underlying wonder of human embodied experience. This does not exhaust the importance of wonder in clinical practice however, and I will conclude with no more than a summary of some of its further 'supporting roles'. Each of these I think deserves further reflection beyond what I can attempt here.

Since the clinical encounter typically involves the two agencies, the two 'intelligences' as I earlier put it, of patient and clinician, it is convenient to let this review rest on their respective shoulders.

The clinician is first and foremost another embodied experiencing flesh, closely resembling the patient in virtually every important respect as regards the two large categories of 'bodily wonder' and 'existential wonder' under which I have considered our patients and their treatment. When the clinician addresses the patient's illness it is also her own mortality that she confronts; when she meddles in the patient's flesh, that flesh is also, in the final analysis, her own. This is easy to overlook and difficult to be mindful of; but one should be mindful of it nonetheless. Both the intimacy of this fleshly transaction, and the respect such intimacy demands, are mutual in character, and they demand that the intimacy be tempered by a kind of 'coolness,'

as Jane Macnaughton and I suggested in the previous Volume in this series.16 The attitude of wonder involves both a preparative pause – before accepting the invitation to try to understand – and an implicit recognition of the limitations of the self and of one's own agency. Together these features of the attitude of wonder offer a good foundation upon which to build 'cool intimacy'.

The clinician also has to avoid complacency about either the general promise of a treatment or its application to an individual patient. Medical knowledge is at any one time provisionally adequate to a proportion of the questions that clinical practice throws up; but embodied human nature is enduringly complicated. The tenacity with which the desperately ill cling to life sometimes appears to suggest that nature is ineradicable; but we also know how fragile is our health and vigour. In undergoing treatment the patient risks disappointment or worse, and in the company of the clinician must submit himself to both the 'autonomy' of nature and the vagaries of circumstance. Treatments sometimes work and they sometimes fail, and (as is perhaps in Liz's mind when she ponders the 95% success rate of the procedure she has just undergone) the odds of success or failure are no more than a description of what is observed, statistically, over a dismayingly heterogeneous population. It is a matter of ontological wonder rooted in the consistency of our nature that, in the medium run, the aggregate numbers do come out right; but it may be a matter of moral wonder rooted in the lust for life that patients take their chances with toxic and uncertain treatments, hoping not to find themselves 'holding the wrong passports' when the numbers are counted.

In the end, perhaps our embodied natures – whether as patients or as clinicians – more strongly underpin, or constrain, the degree of our individual strength of will than we might like to suppose (or than is accounted for in the dominant place in so much health care ethical analysis that is occupied by an attachment to autonomy); for further exploration, see Iona Heath's chapter in this Volume. Notwithstanding, we persist in seeking, offering and taking treatments with all their uncertainty. Our willingness to do so perhaps does not consciously echo the 'wonder of treatment' in the underlying sense that I have tried to explore in this Chapter, but I think the willingness expresses that wonder, nonetheless.

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[1] For instance, Evans M. Music, interrupted, in: Evans M, Ahlzén R, Heath I and Macnaughton J (eds), *Medical Humanities Companion Volume One: Symptom*; Oxford: Radcliffe Publishing, 2008; p.19.

[2] Leriche R, quoted in Canguilhem G. *On the Normal and the Pathological* (transl. CR Fawcett), New York: Zone Books, 1991; p.91.

[3] Schopenhauer A. *The World as Will and Representation* (transl. EFJ Payne), Indian Hills Colorado: The Falcon's Wing Press, 1958.

[4] I am adapting the term from William Burroughs; Burroughs WS. *The Soft Machine*, New York: Grove Press, 1961.

[5] Mann T. *The Magic Mountain*, transl. H.T. Lowe-Porter, London: Vintage Books, 1999; p.276.

[6] Gallagher S, Cole J. Body schema and body image in a deafferented subject, *Journal of Mind and Behavior* 1995; 16: 369-390.

[7] Kant I, *Critique of Pure Reason* (transl. N Kemp Smith), London: Macmillan Press, 1929; pp. 209 ff.
[8] …to echo a term of Wittgenstein's, albeit used in a very specific context and to a very specific purpose in Wittgenstein L. *Philosophical Investigations* (transl. GEM Anscombe); Oxford: Blackwell, 1974; p. 218.
[9] Diamond J, *C. Because cowards get cancer too…*; London: Vermilion (Ebury Publishing), 1999.
[10] Larkin P. The Old Fools, in *High Windows*, London: Faber, 1974.
[11] Magee B. *Confessions of a Philosopher*, London: Weidenfeld & Nicholson, 1997.
[12] Macnaughton J. Seeing ourselves: interpreting the visual signs of illness, in Evans M, Ahlzén R, Heath I and Macnaughton J (eds), *Medical Humanities Companion Volume One: Symptom*; Oxford: Radcliffe Publishing, 2008; 71-85.
[13] Sontag S. *Illness as Metaphor*, New York: Farrar, Strauss & Giroux, 1977.
[14] Larkin P. The Building, in *High Windows*, London: Faber, 1974.
[15] Bryson B. *A Short History of Nearly Everything*, London: Black Swan, 2003.
[16] Evans M, Macnaughton J. Intimacy and distance in the clinical examination, in Ahlzén R, Evans M, Louhiala P and Puustinen R (eds), *Medical Humanities Companion Volume Two: Diagnosis*, Oxford: Radcliffe Publishing, 2010; 89-107; see 96 ff.